

Notre Dame of Mt. Carmel Operation Appalachia

Health History Questionnaire

Participant

Name _____ Birth Date _____ Social Security # _____

Physician's Name _____ Phone# _____

Date Last Physical _____ Tetanus Booster Date _____ Blood Type _____

Emergency Contact Information

Name _____ Relationship _____ Home# _____ Work# _____ Cell _____

Name _____ Relationship _____ Home# _____ Work# _____ Cell _____

Insurance Company Name _____ Policy# _____ Phone# _____

Please answer all questions and explain any "yes" answers (if more room is needed please continue on back)

Have you had/currently have	No	Yes	If responded Yes – Please Explain
A chronic or ongoing condition			
Any prescribed or OTC medications			
Surgery, hospitalization, ER visits			
Any allergies/sensitivities to medications			
Any allergies (e.g., bee stings, pollen, foods)			<i>List Allergy:</i>
Type of reaction: rash/hives/anaphylaxis			
Medication for above reaction			
Concussion requiring medical evaluation			
Memory loss, or have been "knocked out"			
Seizure			
Frequent or severe headaches			
Chest pain			
High blood pressure			
Restriction from activity for medical reasons			
Vision problems/wear contacts/glasses			
Hearing problems/wear hearing aid/implants			
"Burner", "stinger", pinched nerve			
Swelling/pain/sprain/fracture			
Heat related problems (dehydration, fatigue, dizziness, headache)			
Other not listed above			

I certify that the above information is accurate to the best of my knowledge as of the date of my signature.

Participant's Signature _____ Date _____

Parent/Guardian (if youth participant) _____ Date _____

*This information will be made available to health care personnel in case of illness/emergency.
Any pertinent information (allergies/work restrictions) will be shared with the site leaders.*